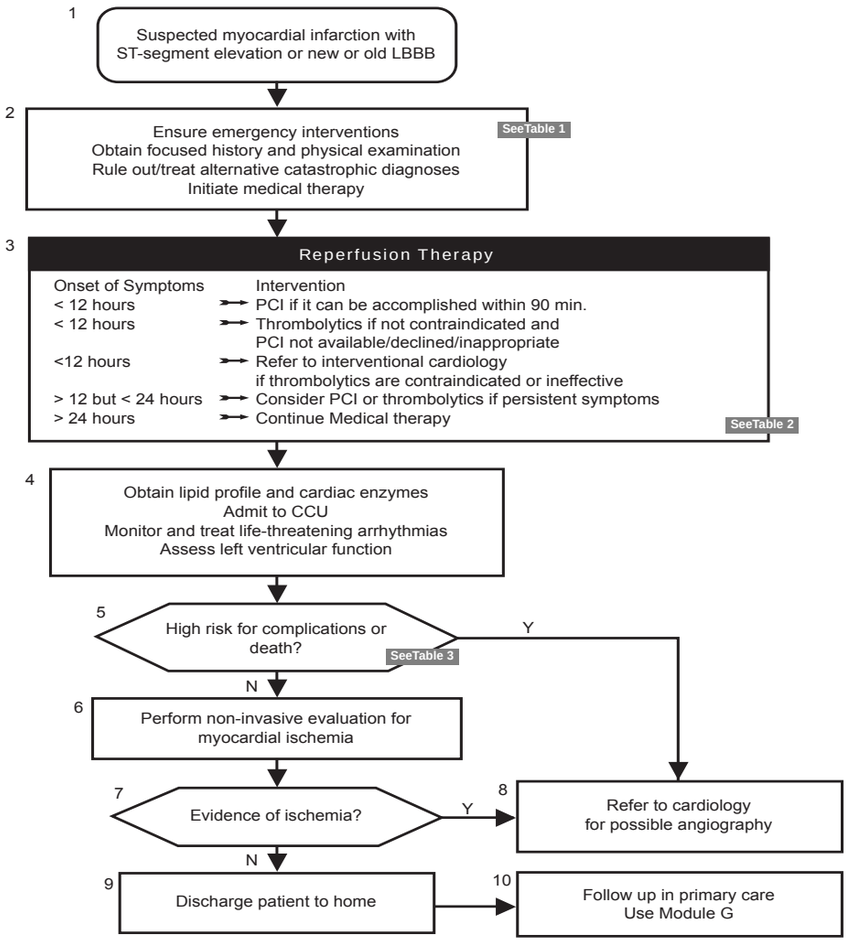
VA/DoD Clinical Practice Guideline Management of Ischemic Heart Disease (IHD) In Primary Care - Module A

Pocket Guide Suspected AcuteMyocardial Infarction or New or Old LBBB

For Management of Initial Evaluation, Unstable Angina/NSTEMI & Follow-Up of Patient with IHD - See Respective Pocket Guide



AMI Medical Therapy

1. Non-coated aspirin
2. Beta-blockers
3. Intravenous unfractionated heparin
4. Nitroglycerin
5. Oral ACE-inhibitors
6. Analgesics

Alternative Catastrophic Diagnoses

- Pericarditis
- Pericardial tamponade
- Thoracic aortic dissection
- Pneumothorax
- Pancreatitis
- Pulmonary embolus

Table 1: Emergency Interventions

- Rapidly triage patients with possible acute MI or unstable angina to a high-acuity setting for rapid diagnostic evaluation and treatment
- Obtain 12-lead ECG
- Institute advanced cardiac life support (ACLS) if indicated.
- Obtain serum cardiac markers (troponin or CK-MB)
- Perform expedited and focused history and physical examination to elicit characteristics of MI and contraindications to reperfusion therapy.
- Administer:
  - Non-coated aspirin (160-325 mg)
  - NTG (spray or tablet, followed by IV if symptoms persist)
  - Beta-blockers in the absence of contraindications
- Ensure adequate analgesia (morphine if needed)
- Identify and treat other conditions that may exacerbate symptoms
- Institute continuous ECG monitoring
- Determine whether the patient meets criteria for emergent reperfusion therapy

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.cs.amedd.army.mil/Qmo
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Management of Patients with ST-Segment Elevation MI or New or Old LBBB

1. Admit to an intensive care unit
2. Initiate heparin, low-molecular weight heparin, if indicated
3. Continue beta blockers
4. Consider ACE Inhibitor therapy in the absence of contraindications

5. ***If less than 12 hours from onset of symptoms***
   - Refer to PCI if intervention can be performed within 90 minutes of presentation in a high volume center by a high volume operator.
   - Initiate thrombolytic therapy, if not contraindicated and not referred for direct PCI
   - Refer to PCI, if thrombolytic therapy is contraindicated or response to thrombolysis is unsatisfactory

6. Perform non-invasive evaluation (cardiac stress test)
7. Refer to cardiology if at high risk for death or recurrent MI and/or LV function
8. Optimize pharmacological therapy for ischemia, angina and CHF
9. Discharge patient to home with appropriate follow-up

Table 2: Reperfusion Therapy

Absolute Contraindications to Thrombolysis

- Previous hemorrhagic stroke at any time
- Other strokes or cerebrovascular events, within one year
- Known intracranial neoplasm
- Active internal bleeding (except menses)
- Suspected aortic dissection
- Acute pericarditis

Relative Contraindications to Thrombolysis

- Severe, uncontrolled hypertension on presentation (i.e., blood pressure >180/110 mm Hg)
- Current use of anticoagulants in therapeutic doses
- Known bleeding problems
- Recent trauma (i.e., within 2 to 4 weeks) including head trauma or traumatic or prolonged (i.e., >10 minutes) cardiopulmonary resuscitation (CPR)
- Recent major surgery (i.e., within 3 weeks)
- Non-compressible vascular punctures
- Recent internal bleeding (i.e., within 2 to 4 weeks)
- Prior exposure to streptokinase (i.e., 5 days to 2 years), if that agent is to be administered
- Pregnancy
- Active peptic ulcer
- History of chronic, severe hypertension
- Age >75 years
- Stroke Risk Score ≥ 4 risk factors:
  - ◊ Age ≥ 75 years
  - ◊ Female
  - ◊ African American descent
  - ◊ Prior stroke
  - ◊ Admission systolic blood pressure ≥160 mm Hg
  - ◊ Use of alteplase
  - ◊ Excessive anticoagulation (i.e., INR ≥ 4; APTT ≥ 24)
  - ◊ Below median weight (≤65 kg for women; ≤80 kg for men)
- Cardiogenic shock (i.e., sustained systolic blood pressure <90 mmHg and evidence for end-organ hypoperfusion, such as cool extremities and urine output <30 cc/hr) and CHF

Table 3: Increased Risk for Complications or Death Following a MI

- Recurrent angina (i.e., spontaneous or inducible)
- Congestive heart Failure (CHF)
- Polymorphic ventricular tachycardia, ventricular fibrillation, or sustained monomorphic ventricular tachycardia more than 48 hours from presentation
- Prior MI
- Ejection fraction (EF) <0.40
- Associated severe mitral or aortic valvular disease (e.g., aortic stenosis, aortic regurgitation, or mitral regurgitation)